Please send this claim form with itemized statement to:
SOUTH DAKOTA RISK POOL PLAN
c/o DAKOTACARE
PO Box 7406
Sioux Falls, SD 57117-7406

SOUTH DAKOTA RISK POOL PLAN CLAIM FORM

#1 GENERAL INFORMATION			
Member's Name (Last) (First)	☐ Male ☐ Female	Date of Birth	Member's Social Security Number
Member's Street Address	City, State and Zip Code		Tel. No.

#2 Fill out this portion ONLY when the claim is for an accidental injury or illness.	
Was Your condition related to: a. Employment? (current or previous) ❑ Yes ❑ No b. Auto Accident? ❑ Yes ❑ No c. Other Accident? ❑ Yes ❑ No	If YES to any situation, please write a detailed description in this section of the form. Date of the Accident _____/_____/_____

#3 Fill out this portion if there may be another insurance company responsible for this claim..		
Name of Insured Person	Date of Birth	Social Security Number
Name of Employer	Address of that Employer	
Name of the Other Insurance Company	Address of that Company	

#4 READ AND SIGN WHERE INDICATED

In consideration of benefits payment under this Group policy, the South Dakota Risk Pool Plan shall have a lien upon any recovery for an injury or disease received from any person, or organization who was responsible for causing such injury of disease, or their insurers.

I authorize any physician or other medical professional, hospital or other medical care institution, insurer, medical or hospital service or prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator to disclose to the claim processor or any benefit plan administrator, or attorney acting on the claim processor's behalf, any medical information and any employment related information regarding the patient. This information will be used to evaluate and administer claims for benefits. This authorization is valid for the duration of the claim. I know that I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

Any person who knowingly files a statement of claim containing false, incomplete or misleading information with intent to injure, defraud, or deceive the South Dakota Risk Pool Plan or any insurance company is guilty of a crime.

ATTACH ITEMIZED STATEMENT

_____ _____

Insured's Signature Date